(ii) CMS withdraws its approval of the organization that deemed the entity to meet a set of quality standards described in § 410.144.

(iii) The entity fails to meet the requirements of paragraphs (a) and (b) of this section.

(2) *Effective date.* The effective date of CMS's removal of an entity's approved status is 60 days after the date of CMS's notice to the entity.

§ 410.146 Diabetes outcome measurements.

(a) *Information collection.* An approved entity must collect and record in an organized systematic manner the following patient assessment information at least on a quarterly basis for a beneficiary who receives training under § 410.141:

(1) Medical information that includes the following:

(i) Duration of the diabetic condition.

(ii) Use of insulin or oral agents.

(iii) Height and weight by date.

(iv) Results and date of last lipid test.

(v) Results and date of last HbA1C.

(vi) Information on self-monitoring (frequency and results).

(vii) Blood pressure with the corresponding dates.

(viii) Date of the last eye exam.

(2) Other information that includes the following:

(i) Educational goals.

(ii) Assessment of educational needs.

(iii) Training goals.

(iv) Plan for a follow-up assessment of achievement of training goals between 6 months and 1 year after the beneficiary completes the training.

(v) Documentation of the training goals assessment.

(b) *Follow-up assessment information.* An approved entity may obtain information from the beneficiary's survey, primary care physician contact, and follow-up visits.

Subpart I—Payment of SMI Benefits

SOURCE: 51 FR 41339, Nov. 14, 1986, unless otherwise noted. Redesignated at 59 FR 6577, Feb. 11, 1994.

§ 410.150 To whom payment is made.

(a) *General rules.* (1) Any SMI enrollee is, subject to the conditions, limitations, and exclusions set forth in this part and in parts 405, 416 and 424 of this chapter, entitled to have payment made as specified in paragraph (b) of this section.

(2) The services specified in paragraphs (b)(5) through (b)(14) of this section must be furnished by a facility that has in effect a provider agreement or other appropriate agreement to participate in Medicare.

(b) *Specific rules.* Subject to the conditions set forth in paragraph (a) of this section, Medicare Part B pays as follows:

(1) To the individual, or to a physician or other supplier on the individual's behalf, for medical and other health services furnished by the physician or other supplier.

(2) To a nonparticipating hospital on the individual's behalf for emergency outpatient services furnished by the hospital, in accordance with subpart G of part 424 of this chapter.

(3) To the individual, for emergency outpatient services furnished by a nonparticipating hospital, in accordance with § 424.53 of this chapter.

(4) To the individual, for physicians' services and ambulance services furnished outside the United States in accordance with § 424.53 of this chapter.

(5) To a provider on the individual's behalf for medical and other health services furnished by the provider (or by others under arrangements made with them by the provider).

(6) To a home health agency on the individual's behalf for home health services furnished by the home health agency.

(7) To a clinic, rehabilitation agency, or public health agency on the individual's behalf for outpatient physical therapy or speech pathology services furnished by the clinic or agency (or by others under arrangements made with them by the clinic or agency).

(8) To a rural health clinic or Federally qualified health center on the individual's behalf for rural health clinic or Federally qualified health center services furnished by the rural health clinic or Federally qualified health center, respectively.